Physician-Assisted Death in the U.S.: Where Is It Legal, What Is Legal, and What May Be on the Horizon?

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Presentation coverage

- How do legal rules for “physician-assisted death” (PAD) compare to rules for “withdrawal of treatment” in the United States (and to PAD in other countries)?
- What can we learn from the differences in rules?
  - Especially on the how we die vs. why we want to die question

Death-hastening practice terms

- "Physician-assisted death (PAD)"
  - Physician prescribes a lethal dose of medication to a dying patient for self-administration
    - OR, WA, MT, VT, CO, CA, DC, Neth, Belg, Lux, Switz, Can
  - Physician infuses a lethal dose of medication into a dying patient
    - Neth, Belg, Lux, Can

Death-hastening practice terms

- "Withdrawal of life-sustaining treatment"
  - Discontinuation of ventilators, dialysis, feeding tubes, or other health care necessary to sustain a patient's life
    - Every state and many countries

Two kinds of legal rules

- Who is eligible for the death-hastening practice?
- What process is required to trigger the death-hastening practice?
  - At first glance, the rules seem to suggest quite different views about withdrawal and PAD in the U.S., but close examination suggests more similarities than differences

Who is eligible? (U.S.)

- Withdrawal of treatment—little restriction
  - A competent patient may refuse any treatment, regardless of the patient's prognosis or type of care
  - Generally permitted for incompetent patients, but living will laws may require a "terminal condition" and no pregnancy
- PAD—significant limits
  - Must be terminally ill (6 months or less to live or terminal condition)
  - Must possess decision-making capacity
  - Must be able to perform the life-shortening act
  - Must be a resident of the state

What process is required (U.S.)?

- Withdrawal of treatment
  - For competent patient, some courts require confirmation of prognosis and capacity by two independent physicians
  - For incompetent patient, varies by state and can depend on prognosis (e.g., stricter rules for non-terminal, non-PVS patients)
- Physician-assisted death
  - Independent physician confirmation of diagnosis, prognosis, capacity, and genuine consent
  - Possibility of psych evaluation
  - Multiple disclosure requirements to patient
  - Two oral and one written request, over a 15-day period

Why the differences in the rules?

- Is it because there are meaningful moral differences between “passive” and “active” practices that hasten death?
- Or do the different sets of rules reflect concerns about how to “operationalize” the relevant moral principles?
- Or both?

Operationalizing moral principle

- End-of-life law reflects a desire to allow relief of suffering from *serious and irreversible* disease
- How do we allow people to choose a quicker death when they are suffering greatly from serious illness?
  - We could say that if you are suffering greatly from serious illness, you can choose a quicker death
    - Which is what the Netherlands and Belgium do for PAD
    - It doesn't matter *how* you die but *why* you want to die

Lessons of history

- In the 1960s-1970s, people disagreed on the question whether life-sustaining treatment could be withdrawn
- The *Quinlan* court recognized a right to have treatment withdrawn, but only for patients with a "dim" prognosis—patients suffering from a *serious and irreversible* disease
  - This was the key moral principle
- In other words, the right to refuse treatment in 1976 looked much more like the right to PAD today

Lessons of history

- But if patients can have treatment withdrawn only when they are seriously enough ill, the government has to decide who must live and who may die based on judgments about patients' quality of life
  - This is not the kind of power a government should exercise

Lessons of history

- Courts abandoned the *Quinlan* standard and now leave it up to *the patient* to consider quality of life—the right to refuse treatment belongs to *all* persons
- But that's okay in terms of the moral principle that you can choose a hastened death when *seriously and irreversibly* ill
  - Because the typical withdrawal of treatment involves a patient who is suffering from a serious and irreversible illness
  - Other refusals typically reflect religious belief—and these refusals are not always respected

End-of-life law

- The distinction between treatment withdrawal and PAD is an important moral distinction
- But maybe not for the usual reasons given
- The distinction provides a legal "proxy" to sort the morally justified death from the morally unjustified death
  - Legal proxies are common—speed limits, voting ages

Legal proxies may need revision

- Death with dignity laws reflect the view that the distinction between treatment withdrawal and PAD does not do a good enough job sorting between morally justified and morally unjustified deaths
- By allowing PAD only for terminally ill persons, the legal rules serve as better proxies for the principle that death-hastening action can be chosen by people who are *seriously and irreversibly* ill

Significance for the future

- Suggests that the terminal illness requirement is a critical one—no coincidence that every state employs it
  - And controversial cases involved non-terminal patients
- Also suggests that expansion of a right to PAD beyond terminally ill patients will require some other proxy for eligibility that avoids case-by-case quality of life judgments

Identifying the morally justified death

- One comes to the same proxy explanation from the view that people should be able to choose death-hastening action as an expression of personal autonomy
  - Difficult to determine whether a choice of death is a *genuine* expression of autonomy
  - Limiting PAD to terminally ill reduces the risk of "false positive" conclusions that the patient is making a genuine expression of autonomy

What else can we expect legally?

- If empirical evidence continues to be reassuring
  - More states permitting PAD by statute
  - Recognition of a constitutional right
    - *Cruzan* case came to the Supreme Court 14 years after the *Quinlan* case
    - *Glucksberg* and *Quill* came to the Supreme Court before there was any US experience with PAD
  - Physician-administration?

Terminal (U.S.)

- Living will statutes often require that patients have a "terminal condition"
  - An incurable and irreversible condition that without the administration of life-sustaining treatment will result in death within a relatively short time.
- PAD statutes require that patients have a "terminal illness"
  - Life expectancy no greater than six months